

## **LA County Policies Related To Death & Dying - Ref #814 & 815**

People who choose EMS as a career sometimes are very uncomfortable to participate in a run where death is the inevitable conclusion because they see death as a failure. Death is an inescapable part of the life experience and understanding how to best manage a dead or dying patient is an important EMS skill. LA County policies 814 and 815 can give guidance in managing situations where a patient is factually dead or has left written instructions concerning the type of treatment they wish to receive or not receive.

Diagnosing death is not always easy. How do you really know somebody is in fact undeniably dead? How do you know they are irreversibly dead such that any investment of time or resources would be a complete waste? Sometimes the exterior mutilation of a body is so extensive that death is completely obvious. Ref# 814 has identified these situations and if you find a patient like this you can be confident in calling them dead and not rendering any treatment.\*

1. Decapitation
2. Massive crush injury
3. Penetration or blunt injury with evisceration of the heart lung or brain
4. Decomposition
5. Incineration
6. Accident victims who are pulseless/apneic and cannot receive care until they are extricated and it is going to take longer than 15 minutes to disentangle them
7. Victims of a blunt trauma mechanism who are pulseless/apneic and have no organized EKG activity on EMS arrival
8. Pulseless/apneic victims in an MCI situation
9. Drowning victims who have been submerged for one hour or more
10. Patients displaying rigor mortis
11. Patients displaying post mortem lividity

In these situations death is so certain that you do not even need to contact base hospital for direction you only need to document your assessment findings describing what you found. However, one important set of assessment findings that you MUST document involves the last two situations. (rigor & lividity)

Rigor mortis is the stiffness that appears in the body after death. It develops because as the muscle cells die they perform anaerobic metabolism and change their molecular composition. At the moment of death a body is limp. The stiffness in a dead body slowly comes on and slowly disappears again returning to limpness. Patients who have been bedridden (such as convalescent hospital patients) and not moved their muscles & joints regularly also develop stiffness in their body, this is called contractures. It is not uncommon to confuse contractures in a living body with rigor mortis in a dead body.

Lividity happens when upon death the pre and post-capillary sphincters dilate and allow an unlimited blood flow into the capillary bed. Blood flows through the arteries/veins by gravity and engorges the capillaries in the low hanging or dependant parts of the body. The congestion of blood can easily be seen below the skin. Post mortem lividity looks much like bruising on a living body.

Because rigor & lividity are hard to distinguish from contractures and bruising, if a paramedic is going to call somebody dead on these findings their assessment must include (and document on the PCR) a specific assessment of their respiratory, pulse and neuro status. Paramedics must open the airway and look/listen/feel for breathing for 30 seconds AND AUSCULTATE an apical pulse and palpate a carotid pulse for 60 seconds AND then check for absence of pupil reflexes and painful stimuli.

Whenever paramedics respond to a victim of (non-traumatic) cardiopulmonary arrest they should always begin BLS measures, then quickly before starting ALS procedures, they should look for indications to stop all treatments and call the patient 'dead'. One situation is where the patient is found to be in asystole without CPR and it is estimated that it has already been without CPR for 10 or more minutes. In this situation the patient can be called dead and left at scene without making any base hospital contact.

The second situation is when the patient is in (non-traumatic) cardiopulmonary arrest and paramedics are presented with papers that state that the patient refuses resuscitation. These papers have different names that include; DNR, Advance Health Care Directive (AHCD), Physicians Order for Life Sustaining Treatment (POLST) Durable Power of Attorney for Health Care and Living Will. (There are technical differences between each that are not discussed here and some titles are considered technically obsolete) While each form is a little different they are all meant to convey to responders the treatment that the indicated person wishes to receive at the time of their death. Most likely a friend or family member will give you this documentation.

First thing upon receiving them is to verify that the papers actually describe the person who is in full arrest. Next you should establish the relationship between the living person and the dying person. (Is the living person named on the papers?) Finally you should look to see what type of treatment the person has requested. It is unlikely that the papers are requesting a full ACLS work up. Most likely they are requesting no treatment after cardiac arrest. In situations where the papers and the family/bystanders are all in agreement that the dying person wanted no treatment at the time of death, then paramedics can cease all BLS treatment and call the patient dead without making base hospital contact and fully documenting the situation of course.

In situations where the papers are unclear (or unavailable) or the family/bystanders are in disagreement about the treatment the dying person had requested or the paramedic feels uncomfortable and would like additional direction they are always free to and should contact their base hospital. The base hospital may advise transport with BLS measures and then sort out the situation at the hospital.

Up to this point we have used the phrase "calling somebody dead". More technical language is pronouncing death and determining death. Interestingly, the term "pronouncing" death does not appear in California law. After a death an MD must file a death certificate listing the cause and the time of the death. The time listed on the death certificate is reflective of the time death was pronounced. The doctor's signature is an endorsement that they have been treating the deceased for a chronic medical condition and therefore know the cause of death and the time of death to the best of their knowledge. It is not a certification that the doctor pronounced death or that they were even in attendance at the time of death. In the state of California to pronounce death is really nothing more than stating or agreeing on a time that the death has occurred.

Determining a death is more involved. To make a determination of death is an indication that a person with medical training has performed a medical assessment (including physical exam and vital signs) that has led to

a medical diagnosis of death. Determining death is more involved than just pronouncing death. The Paramedic assessment described earlier in this paper is the process necessary to determine death.

Transporting a patient to a hospital for treatment is expensive. There are costs for the ambulance and the ED staff and any medications or supplies. If a patient has no chance for survival it makes no sense to transport them to a hospital for care that is futile. CPR and other treatments are known to be less effective in a moving ambulance. In situations where a patient is in (non-traumatic) cardiopulmonary arrest and there is no indication to determine death as described above then paramedics should NOT transport until there has been a Return of Spontaneous Circulation (ROSC). Stay and work up the patient in the field. But for how long?

There are many reasons why a cardiac arrest might happen and each patient has their own unique medical history so LA County does not have any exact criteria specifying when a patient without ROSC should be pronounced, but Ref #814 does state that after 20 minutes of resuscitation without ROSC, then pronouncement should be considered. In these cases base contact will have been made and the Paramedics and hospital are all aware of the entire situation and the effectiveness of all treatments. When the base physician has determined that any further efforts are futile the base physician may pronounce the patient dead. (Note: the physician's pronouncement is based on the physical findings and determinations made by the paramedics on scene that have been relayed to the base)

So, the patient is dead, now what? Whether they ultimately are or not, all field deaths are initially to be considered Coroner's cases. This means that after pronouncement the body should not be moved without Coroner's authorization and all equipment should be left in place (ETT, IV). EMS personnel should remain on scene until law enforcement arrives to protect the scene for the Coroner. There are situations when bodies are removed from the scene and sometimes transported to the hospital. Situations where violence is an issue or the body is in public view or blocking traffic then an immediate removal might be best. You should have the Coroner's permission before any removal is made. Make base station contact to document your situation.

Because death is an uncomfortable emotional experience, after pronouncement the EMS personnel should then turn their attention to providing emotional support to the surviving family members. The shock of the situation might provoke medical symptoms in the survivors that require evaluation, but at a minimum paramedics should comfort them and answer any questions they have about the situation and any treatment that was rendered.

While there is more to making a death notification than can be explained here, remember that is always best to be direct and not use euphemisms. Describe the person as being "dead". They are not "asleep" or "passed on" or "in a better place" or "expired" or "moved on". It is also wise to remember the stages of grief and that the family might react with angry aggressive behaviors as well as sadness and depression. These behaviors might be directed at EMS personnel.

One question that is commonly asked by survivors is; "What should we do now?" Do not attempt to explain about whether this might be a Coroner's case or not and how that might or might not affect the disposition. Instead always direct the grieving persons to draw together for support ("Can we call somebody for you?" "Is there somebody who can come and stay with you?") Then direct them toward funeral planning. A funeral director is a professional who is well versed on disposal of human remains. The family does not need to worry about the legal necessities required for disposal of human remains. By making one call to a funeral home all

the family's needs can be met. As a professional, the funeral director will help the family choose between burial or cremation or the type of funeral service they would like if they would like any service at all. It is the job of the funeral director to liaison between the Coroner and the family and ensures all the necessary paperwork is taken care of. A funeral director does not have to be contacted immediately, but eventually this is where they will need to go. Sometimes the family has already purchased a funeral plan and the choices have already been made.

Sudden Infant Death Syndrome (SIDS) has its own considerations. A normal baby is laid down to sleep and is later found dead. SIDS is always unexpected and always very emotional. (Babies are not supposed to just die) Nobody knows exactly what causes SIDS but it has been seen that by positioning babies on their back for sleep the rate of SIDS has declined.

From a paramedic point of view the run will be for an infant in full arrest. During the initial assessment Paramedics should carefully look for criteria that could allow them to determine death (rigor and lividity). If it is seen, DO NOT attempt resuscitation. The baby is dead and cannot be revived. Despite the emotional aspects of the event no good can come from false hope and the transport of a corpse. Instead notify the family of the death and allow them to begin grieving.

Infant deaths are always Coroner's cases. Leaving the body on scene ensures that when the Coroner arrives to investigate, it is reflective of the conditions that existed at the time of death. This will greatly aid the Coroner in understanding what happened and possibly solving the mystery of SIDS and perhaps saving other infants someday.

If the baby shows rigor and lividity and you determine death per Ref #814 then no base contact is required. However, because of the emotional aspects of an infant death or if any questions arise, feel free to contact the base hospital. Of course if the infant is NOT showing signs of obvious death (no rigor or lividity?) then resuscitation should be performed and base contact made.

There is one other situation that can exist around a death bed situation. A POLST form has several sections. The first is an area to describe whether the person wants resuscitation procedures (DNR). The next area describes the medical interventions the patient wants to receive. One box states "Comfort Measures Only". It instructs responders to use any means possible to relieve pain and suffering. This includes the use of analgesic medications. (Other informational sheets describe how to assess for pain). LA Co Ref #815 reminds Paramedics that if this box is checked they can and should (via Ref #806 or with orders from a base hospital) administer whatever medications are appropriate to relieve pain, dyspnea or treat hemorrhage. After treatment, it is NOT necessary to transport the patient to the hospital. If comfort measures were able to meet the patient's needs then there is no reason for transport, leave them on scene.

*\*All text from References 814 and 815 has been edited for clarity and flow. Please consult the original policies to view the exact wording.*